

MCM Commission

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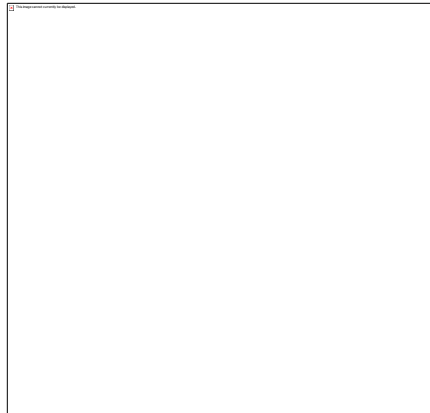
**NH Department of Health
and Human Services**



August 7, 2014

Setting the Context

Care Management Program @ 7 months



Agenda for Today

- **Monthly Enrollment Update**
- **Review of Key Program Indicators Report**
- **Review of priority functional areas we are addressing**
- **Recommendations for Issue Resolution going forward**
- **MHP transition**
- **Update on implementation of the NH HPP in MCM**

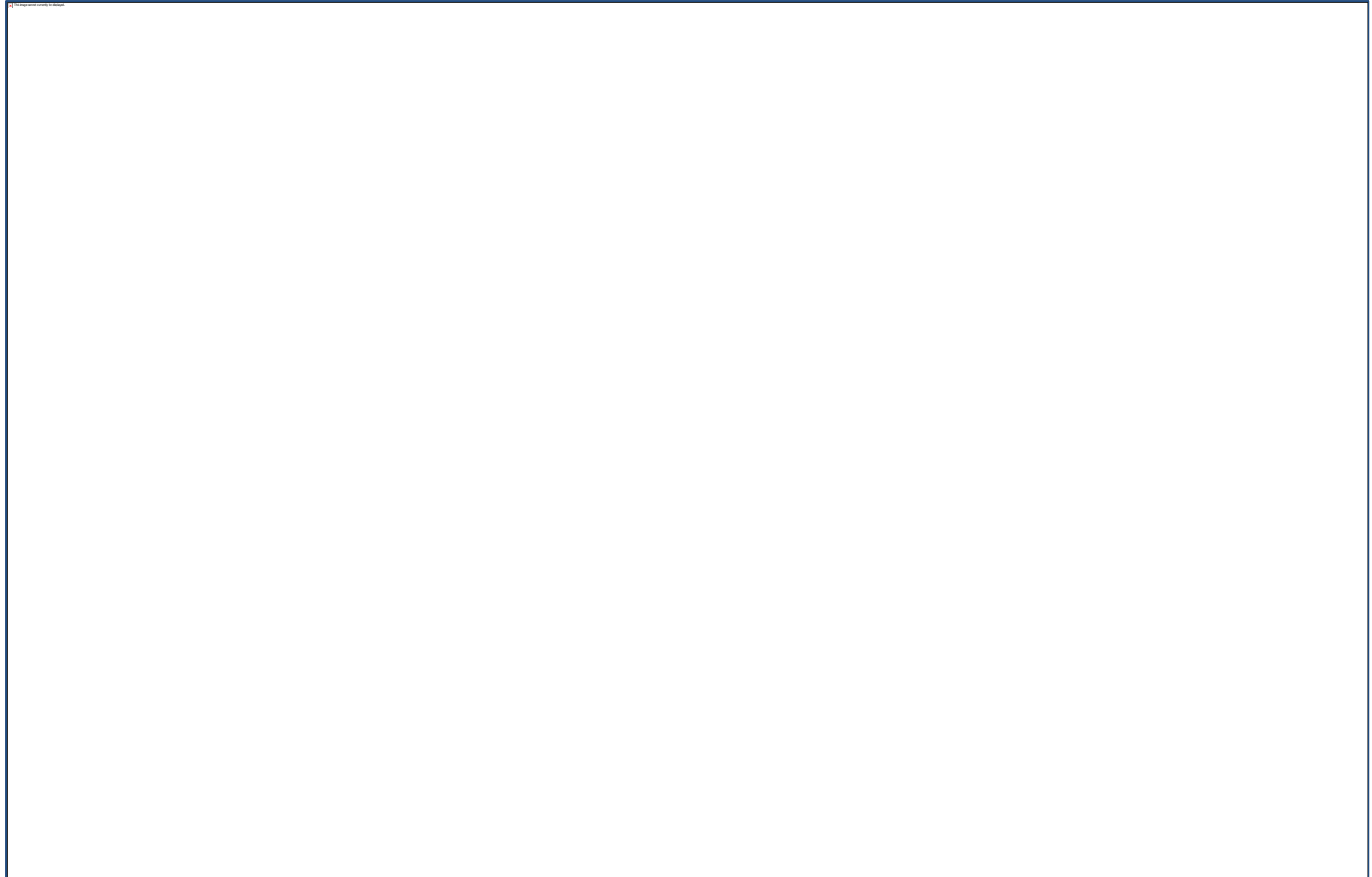
Guiding Principals of NH MCM

- **Whole person management and care coordination**
 - **Foundation for Medicaid transformation**
- **Increase quality of care – right care, at the right time, in the right place to improve beneficiary health and quality of life**
- **Payment reform opportunities**
- **Budget predictability**
- **Purchasing for results and delivery system integration**

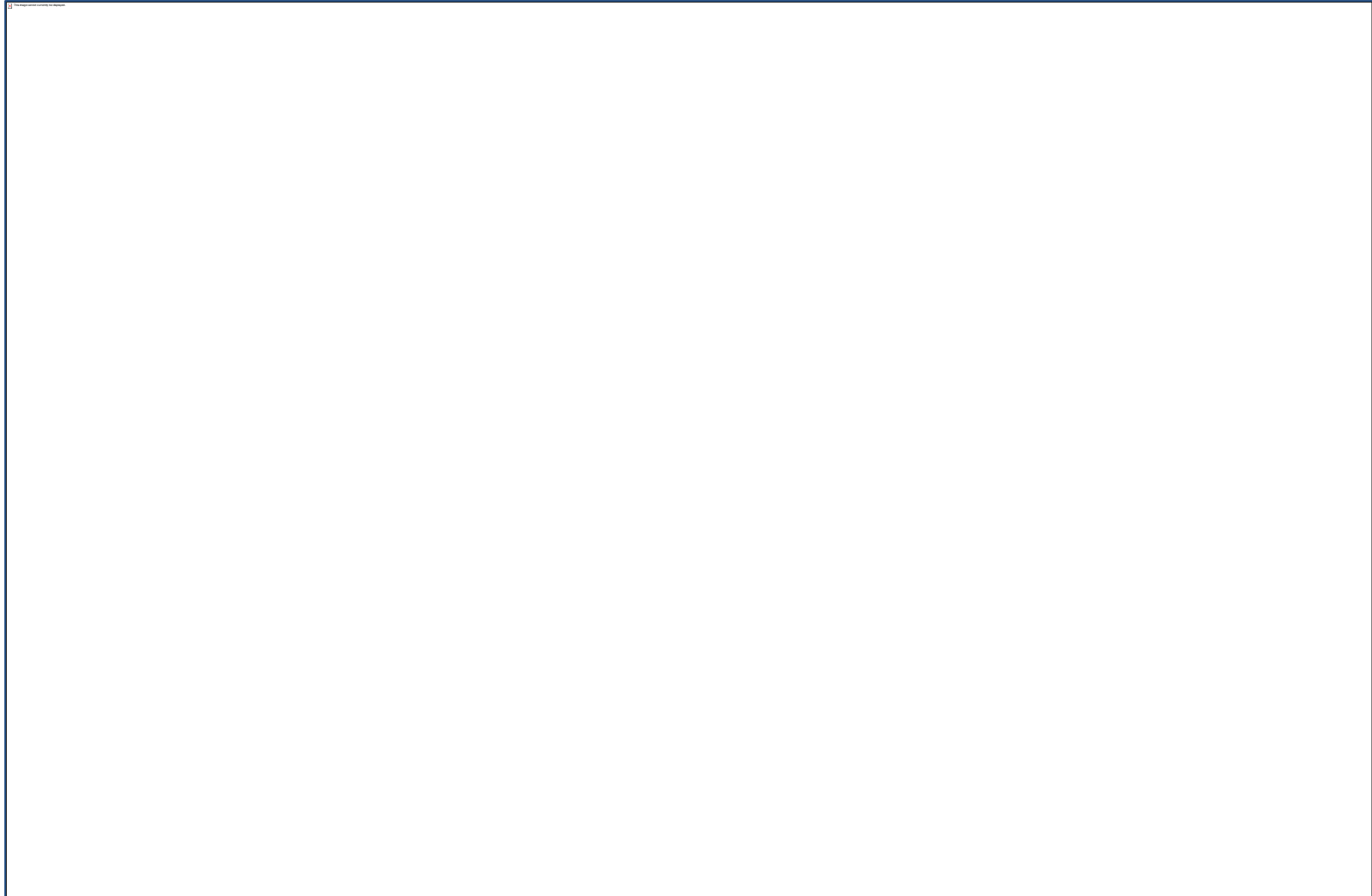
Monthly Enrollment Highlights



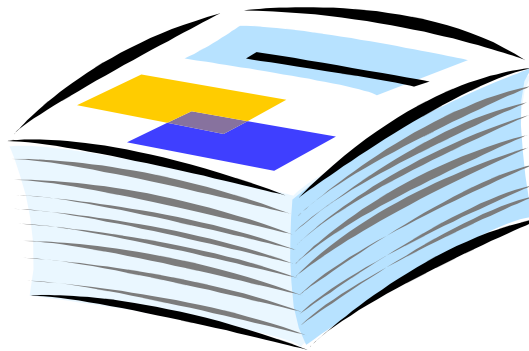
Monthly Enrollment Highlights, cont.



Monthly Enrollment Highlights, cont.



Key Performance Indicator Report



Quality

- **One of the clearest priorities in moving to a MCM model was the ability to achieve better health outcomes for Medicaid members.**
- **The commitment to quality improvement is demonstrated in the comprehensive data reporting obligations in the contract.**
- **This enhanced and comprehensive focus complements the strategic intent of DHHS: Whole Person Care and Greater Population Health**
- **Through data and analytics, we are just starting to be able to set a baseline enabling DHHS to quantify how MCM is improving the quality and adapt as the data becomes available.**

MCM Key Indicators Report

- **DHHS tool for monitoring program performance**
- **Organized by various domains that represent indicators of the health of the program**
 - **This provides foundation for comparison of the two MCOs.**
- **Some indicators and metrics have prescribed benchmarks such that performance and compliance is illustrated.**
- **Some indicators require a trend in order to show performance and compliance over time.**
- **Some indicators are reported monthly, some quarterly and still more are reported annually.**

MCM Key Indicators, cont.

- **Measures collected capture some health quality metrics as well as customer experience metrics.**
- **All measures reported from the MCOs come in well after the last month in the measurement period.**
- **DHHS then validates the submission and compiles the results for publication.**
- **Some measures are reported by the MCOs, other measures are captured independently by the External Quality Review Organization (EQRO).**

MCM Key Indicators, cont.

Metrics in the Key Indicators Report include:

- **Access & Use of Care**
- **Customer Experience of Care**
- **Provider Service Experience**
- **Utilization Management**
- **Grievance & Appeals**
- **Preventative Care**
- **Chronic Medical Care**
- **Behavioral Health Care**
- **Substance Use Disorder Care**
- **General**

MCM Key Indicators, cont.

- **A MCM-QD Users Guide is nearly complete. It will outline for each measure how often it is captured, why is it captured, and how that measure gives insight into the health of the program.**
- **Please turn to the Key Indicators Report**

EQRO

- Required of all Medicaid Managed Care programs.
- Quality in this context means “the degree to which an MCO increases the likelihood of desired health outcomes. . . .”
- EQROs must be independent of both the state Medicaid agency and the MCOs.
- For more information, see 42 CFR §438.301 *et seq.*

Recent EQRO Activity

- **Utilizing the expertise of the Horn Group, focus groups were conducted in May 2014 to capture member feedback on the transition to MCM.**
- **DHHS provided the Horn Group with a blind list of MCM members in Hillsborough and Belknap Counties from which the Horn Group took a random sample and recruited participants in the focus groups.**

Executive Level Findings

Horn Focus Groups

- **Participants indicated they had received adequate notice of the change to MCM, but still struggled to decide on the right plan. Most said they selected a plan based on participation of their PCP.**
- **Many participants stated they did not understand the MCO, the benefits or coverage detail. This was also observed in participants confusion on the difference between the roles of the MCO and Medicaid.**

Executive Level Findings

Horn Focus Groups

- **Overall, participants reported their access to doctors stayed the same, but they experienced difficulty with specialists and pharmacy.**
- **Participants were equally divided in their assessment of the quality of their PCP care, but did not correlate this to the MCO.**
- **Most felt their care was well coordinated and that they had an active role in their care and that of their children.**

Executive Level Findings Horn Focus Groups

- **Participants suggested certain improvements including adult dental care, and easier access to pharmacy.**
- **Participants also suggested Medicaid expand to include adults and provide clearer rules regarding eligibility.**

Key issues being addressed - path forward



Focus Areas

- 1. Service Authorization for therapies (PT/ST/OT)**
- 2. Authorization for medications (pharmacy)**
- 3. Authorization for non-emergent medical transportation (NEMT)**
- 4. Administrative burdens**

Troubleshooting Therapy Auths

- **Authorization of therapies (OT/ST/PT)**
 - Review existing reported data
 - Review of requested as ad hoc reports by MCOs ran at our request
 - Determine the scope of the problem
 - Develop solutions for resolution
- **Preliminary results confirm the greatest difficulties are experienced in authorizing services for children with chronic health care needs.**

Troubleshooting Therapies,

- **If the data and oversight confirm this theory, steps toward resolution include, but are not limited to:**
 - **Comprehensive review of applicable rules and policies for both clarity and compliance.**
 - **Determination if proper policies were applied incorrectly or incorrect policy was applied based on member presentation.**
 - **One-on-one provider support in completion of service authorization requests.**
 - **Dedicated provider forum for therapies providers.**

Troubleshooting Pharmacy Auths

- **Authorizations of Medications:**
 - Based on an initial sample of denials of authorizations, DHHS is requiring various short term corrective action strategies as we comb data to determine the scope of the issue and the appropriate response.
 - This topic is far more complicated that one might assume; isolating root causes is more challenging as a result.
 - The process of working through the data, review of policies for compliance and review of the professional literature as well as NH industry standards will take time.
 - DHHS will report out as this work continues.

Troubleshooting Transportation

- **Contract requirements built on a ‘purchase for results’ model; they are not prescriptive.**
- **The MCM transportation model increases safety, quality and consistency by mandating:**
 - **Minimum safety, inspection and insurance standards for vehicles;**
 - **Background checks for all drivers;**
 - **Safety protocols for unaccompanied minors receiving NEMT.**
- **Transportation providers are rewarded for timely, courteous service by having first right of refusal of new ride assignments.**

Troubleshooting Transportation, cont.

- **Authorizations of Transportation:**
 - This is a recent example of the need to report problems to the MCO and DHHS in the first instance. While complaints have made their way to the Commission, there have been very few issues reported to DHHS and the MCOs. The transportation data elements in the Key Indicators Report reflect this. See 4-4 and 5-2 in the Key Indicators Report.
 - Additionally, it is important to capture the date of the issue. Problems persisting in recent weeks/months are compelling in that they would not appear to be growing pains from program start.
 - Complete stats consistent with 10.4.3 of the contract will be available in September.

Recommendations for Issue Resolution

- **In March DHHS reported to the MCM Commission about how issues are resolved within the MCM framework including discussion of grievances, appeals, as well as general escalation of matters within the MCO.**
- **Our “no wrong door” approach at program start met member needs quickly, but may have led to confusion later.**
 - **For fastest results, members should start by calling the MCO customer service line. Escalate to a manager as appropriate.**
 - **If customer service is unable to resolve the matter, grievance and/or appeal may be warranted.**
 - **If the member has not prevailed in either grievance or appeal, an appeal to DHHS may be merited.**
 - **Intervention from DHHS or other authorities should be sought for systemic concerns or where the MCO is unresponsive.**

Issues Resolution

- Every complaint is taken seriously at the MCO and DHHS level.
- It is imperative that reported issues have sufficient detail
- Providers and members should avail themselves of grievance and/or appeal for the fastest possible resolution
- Both MCO grievances and appeals can be expedited when the situation merits.
- Collectively need to redirect members and providers to the MCO or DHHS.
- The processes in place comply with applicable laws, rules and policy but must be used to realize their potential.

MHP Transition

- **As of August 1, all MHP members have migrated to a new health plan (31K).**
 - **46% Self-selected by July 10th**
 - **Members split roughly 50/50 to two plans**
- **As of this date, this appears to have been fairly seamless for members, monitoring will continue.**
- **Many data exports created to ensure continuity of care through the transition.**
- **High touch care coordination and transition planning has occurred in partnership between MHP, DHHS and the receiving MCO for individuals who are at a critical period in their treatment as well as for pregnant women.**

NHHPP MCM Implementation

- Contracts were approved on July 16.
- Bi-Weekly meetings occur with the MCOs to work through implementation milestones.
- Readiness Reviews will be conducted on August 13 & 15.
- Provider forums are underway and are very well attended. Forums will continue into September.
- NHHPP fee schedule has been posted to the Xerox webpage.
- Communications to potentially eligible individuals is ongoing (letter are posted to the NHHPP web page).

NH HPP MCM Implementation

- Key Dates
 - July 1 Enrollment began
 - August 1 HIPP Cost Effectiveness began
 - August 15 Coverage begins for fee for service
 - September 1 MCM coverage begins
- 8,276 Enrollees as of 8/6
 - 8,207 ABP
 - 69 standard Medicaid
 - 361 referred to HIPP for cost effectiveness test



Questions?